

**Application for the Registration of and for a Permit to Open and Conduct
A New Part-Time, Limited, or Conditional Pharmacy in the State of South Dakota**

TO: South Dakota Board of Pharmacy
4305 South Louise Ave., Suite 104
Sioux Falls, SD 57106

Phone: 605-362-2737
Fax: 605-362-2738

I, _____, Certificate No: _____, being a pharmacist in good standing registered under the laws of this state, hereby apply for the original registration of, and for a permit to open and conduct a new Part-Time, Limited, or Conditional pharmacy as described herein and over which I will have full and complete control in the active management thereof as set forth in this application. I enclose remittance of **\$160.00** for the fee as required by law.

It is understood that the word "pharmacy" throughout this application means "Part-Time, Limited, and Conditional pharmacy".

I agree to display the Registered Part-Time, Limited, and Conditional pharmacy certificate in a conspicuous place in the pharmacy and to report to the Executive Secretary of the Board of Pharmacy any change in the location of the pharmacy or any change in the ownership of the merchandise and fixtures of the pharmacy within ten days of such occurrence. I will notify the Board of Pharmacy of any change in the pharmacist permittee at least ten days prior to such occurrence. I will surrender the pharmacy certificate for cancellation of the cessation of business as a pharmacy, upon change of ownership, or when the permit to conduct a pharmacy has not been transferred as provided by law.

(A Complete Answer Must Be Given to All Questions—Use the Reverse Side if More Space is Needed for Answers)

1. Under what name and title is the new pharmacy to be registered?

2. List the name of the pharmacist-in-charge, pharmacy address, phone number and fax number:

Name _____ Certificate No. _____

Pharmacy Address _____ State _____ ZIP _____

Business Phone _____ Fax _____

3. Who will be the owner of the building or space to be occupied by the proposed new pharmacy?

(If corporation, enter the names of all officers and directors of such corporation on the attached affidavit.)

If the building or space to be occupied by the proposed new pharmacy is to be rented, will the amount of rental be based upon the volume of business done by the proposed new pharmacy? ____ Yes ____ No

4. Who will be the owner of the merchandise and fixtures of the proposed new pharmacy?

Name of individuals, partners or corporation

*If corporation, complete and attach Affidavit Supplement to Application for a Permit to Conduct a Pharmacy
or Renewal Where Pharmacist(s) Applicant is not sole Owner of Merchandise and Fixtures*

5. Will you be the owner or lessee of the merchandise and fixtures of the proposed new pharmacy to the extent that you will be self-employed? ____ Yes ____ No

If your answer is "No" – By what individual(s) or corporate officer(s) will you be employed?

6. What is the type of pharmacy to be registered under this application?

(Hospital, Nursing Home, Related Facility)

If hospital or nursing home, do you have an organized medical staff? _____

Send copy of organizational chart showing placement of pharmacy department.

If related facility, describe in detail your type of service. _____

7. How many hours per week will the pharmacy be open? _____

8. How many registered pharmacists will be actively engaged in the proposed new pharmacy?

Full Time _____ Part Time _____

9. Will a registered pharmacist be on duty in and in charge of the proposed new pharmacy at all times when space to be registered as a new pharmacy is kept open? _____ Yes _____ No

Size of space to be registered _____

10. Will the pharmacy be kept in a clean and sanitary condition? _____ Yes _____ No

11. Will the pharmacy keep on file at all times required references? _____ Yes _____ No

12. Will the proposed new pharmacy maintain the following equipment:

a. A balance with a delicacy of not less than one-tenth grain? _____ Yes _____ No

b. Prescription equipment of such kind and quality as will enable the pharmacist to meet all prescription requirements? _____ Yes _____ No

c. A perpetual inventory of the receipt and distribution of C-II drugs under Controlled Substances Act? _____ Yes _____ No

d. Proper labels? _____ Yes _____ No

e. Permanent filing convenience for all prescriptions? _____ Yes _____ No

f. Suitable locked space for narcotics and dangerous drugs? _____ Yes _____ No

g. Refrigerated storage space for biologicals and drugs affected by extreme temperatures? _____ Yes _____ No

h. Sink with hot and cold running water? _____ Yes _____ No

13. Will the pharmacy be in a separate room and locked when the pharmacist is not on duty? _____ Yes _____ No

I declare and affirm under the penalties of perjury that this application has been examined by me, and to the best of my knowledge and belief, is in all things true and correct, and that the provisions of law, and Board of Pharmacy Rules and Regulations relative to conducting a pharmacy in the state of South Dakota, will be faithfully observed during the period for which a permit to open and conduct a new Part-Time, Limited, or Conditional pharmacy in the state of South Dakota shall be issued.

**Supplement to Application for Permit to Conduct a Pharmacy or Renewal Where
Pharmacist Applicant is not Sole Owner of Merchandise and Fixtures**

AFFIDAVIT

State of _____)
) ss
County of _____)

**Complete first portion of form as
Individual/Partnership or as a
Corporation**

INDIVIDUAL OR PARTNERSHIP: I, _____, being first duly sworn, depose and say that I am the (non-pharmacist) owner of _____ percent of the merchandise and fixtures in the place of business for which pharmacy registration is applied for in the attached application for registration of Permit to Conduct a Pharmacy or renewal in South Dakota.

OR

CORPORATION: I, _____, being first duly sworn, depose and say that I am the _____ of _____, a corporation and one of its managing officers and directors; that said corporation is the owner of the merchandise and fixtures in the place of business in the attached application for registration of and for Permit to Conduct a Pharmacy or renewal in South Dakota.

That said place of business may be registered as a pharmacy and conducted in accordance with the laws of the State of South Dakota, said Individual/Partnership or Corporation hereby delegates complete responsibility for the pharmaceutical

services to Registered Pharmacist-in-Charge _____ Cert# _____
(Pharmacist listed here must be the same as person signing the Application Form)

to have full charge of the merchandise and fixtures at said place of business in the same manner, and to the same degree as though said pharmacist were the sole owner of such merchandise and fixtures. It is further represented and said that if any non-pharmacist owner/corporation is actively engaged within such Pharmacy, after it is so registered, that such non-pharmacy owner, corporate officer, employee or agent of non-pharmacist owner/corporation will submit to administration and guidance of the Registered Pharmacist named herein, in the same manner and to the same degree as though said non-pharmacist owner, corporate officer, employee or agent of non-pharmacist owner/corporation were an employee of the Registered Pharmacist named herein.

Signature of Non-Pharmacist Owner or Corporate Officer

Subscribed and sworn before me this _____ day of _____, 20 _____.

(Seal)

Name of Notary Public

Enter below – Complete list of managing officers and directors. (Use extra sheet if necessary)

<u>Title/Officer</u>	<u>Name</u>	<u>Address</u>

Have you, or any other managing officers and directors, plead guilty or no contest, or received a suspended imposition of sentence for a felony or other criminal offense (excluding minor traffic violations)? __Yes __No